ISBVI Current Medications & OTC Authorization Form
Academic Year 2020-2021

Student Name:_____ Date of Birth: _____

Allergies: ___ YES ___ NO

If YES, please include any seasonal, environmental, food, or medication allergies and reaction:

_____

Current Medications:

Medication	Dose	Frequency	Time Given

(Please use a separate page if not enough space is provided)

Permission for Use of Over the Counter (OTC) Medication:

All students will be evaluated prior to administration of any medication. If your child becomes symptomatic, he/she has the option of receiving OTC medication that may relieve mild to moderate symptoms. Please check all medication the health center can administer in such cases:

____ Tylenol (Acetaminophen) ____ Advil/Motrin (Ibuprofen) ____ Claritin (Loratadine)

____ Sunscreen/Sunblock ____ Mucinex (Guaifenesin) ____ Diphenhydramine (Benadryl)

____ Dextromethorphan (Robitussin) ____ Lubricating eye drops ____ Cough/Throat Lozenges

____ Antibiotic ointment ____ A&D Ointment ____ Hydrocortisone 1% cream

____ Antacids (Tums)

PARENTAL CONSENT

I hereby give consent for my child to participate in the School Health Services Program. This program includes emergency care, health appraisal at school and monitoring for communicable diseases.

I am aware that for my child to receive any medication or medical treatment at school, I must provide the appropriate paperwork. All regularly dosed medications must be brought to school by an adult. If a student in the 9th grade or older and needs to receive a medication, parents may fill out the appropriate paperwork to transfer medication to the Health Center via student. All medications and/or treatment taken, equipment, or supplies needed regularly must be supplied by the parent/guardian.

In case of serious accident or illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to contact one of the adults listed on the Emergency and Contact Information Form whom I have designated to notify in an emergency. In the event the emergency contacts cannot be reached, the school may make whatever arrangements are necessary to provide care and treatment for my child. When necessary, and in the event that I, or any of the emergency contacts cannot be reached, school personnel have my permission to request transport of my child to the nearest emergency room. Under such circumstances, school personnel have my permission to release the information on this form to emergency personnel. I understand and agree that I will be responsible for any emergency medical services fees.

In case of accident or illness where, in the best judgment of school personnel, emergency treatment of my child is not needed, but where he/she is unable to remain at school, I request the school to contact me to pick up my child. If the school is unable to contact me, I understand that one of the adults listed on the Emergency and Contact Information Form whom I have designated to notify in an emergency and who are also designated to pick up my child will be contacted.
I understand and agree that certain educational records of my child may be shared with the School Board's health care partners as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by health care personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such treatment records. I understand and agree that it is my responsibility to notify the school of any changes in the information recorded on this form.

I understand that any medications provided by myself to be given in the school setting will be administered as directed on the commercial or pharmacy printed label.

I certify that the information I have provided on this Medical Information Form is accurate, true and correct.

Parent/ Guardian Signature_____ Date: _____